Income Maintenance Administration
Department of Human Services
Government of the District of Columbia

Recertification for Medical Assistance

(Medical Assistance includes Medicaid, DC Healthy Families, Medical Charities and Medicare Buy-In)

DATE: Census Tract:
DHS-1209 (06/03) MA NO:

Your Medical Assistance expires on _____. You must complete this form and return it in the enclosed envelope before your Medical Assistance expires. **If your Medical Assistance family includes children, you must answer the questions in Parts A, B, C and E of this form and you only have to provide proof of the income you report on this form.** If your family does not include children, you must complete Parts A, B, C, D and E on this form. You must also submit proof of all income (except SSI, Social Security, DC Unemployment or DC Public Assistance), resources and insurance. If you do not complete the Parts you are required to answer and/or do not sign this form, your recertification will be considered incomplete and your Medical Assistance will be terminated. If you require help with this form, call (202) 724-5506.

SEND TO:

Part A:

1. FAMILY MEMBERS LIVING WITH YOU AND RECEIVING ASSISTANCE						HOME TELEPHONES NUMBERS			
Last Name	First Name	Middle Iniitial	Date of Birth	Sex (M/F)	INS Code	Social Security No.	Individual MA No.	Relation to You	Check Family Members Not in Home

Part B:

1. (A) If any family member listed in Part A has left home, cross out their name and list the date they moved out.
   (B) List the name and Date of Birth of any new family members: _____

2. If you have moved, write in your new address and phone number: _____

Part C:

1. List all gross income received from employment for yourself and adult members of the household (including self-employment).

Your Gross Earnings

Amount earned: $_____ ❑ No Income

(check one) ❑ Hourly ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Yearly

Hours worked each week: _____

Employer Name and Phone Number (Attach extra page if necessary)

If self-employed, check here: ❑ Self-Employed

Spouse or Other Adult Member's Gross Earnings

Amount earned: $_____ ❑ No Income

(check one) ❑ Hourly ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Yearly

Hours worked each week: _____

Employer Name and Phone Number (Attach extra page if necessary)

If self-employed, check here: ❑ Self-Employed

2. List all other income received by members of the family including the income of children.

Source of Income	Who Receives This Income?	Amount of Income	How Often is the Income Received?
Child Support		$	
Alimony		$	
Social Security Benefits		$	
SSI		$	
Worker's Compensation		$	
Other (please explain)		$	

3. If you or someone in your family pays for dependent care (child care or for care of an adult who lives with you who cannot care for himself) in order to work, please give us the following information. (This information may help your family continue benefits.)

Name of Person Who Works	Person(s) Cared For	Monthly Amount Paid	Name of Dependent Care Provider	Telephone Number of Dependent Care Provider
		$		
		$		

4. Please provide information about an absent or deceased parent of a child for whom you want benefits to continue. If you do not provide this information, it will not affect your child's eligibility but it may affect yours unless you have a good cause reason for not providing it. An example of a good reason is fear of physical, sexual or emotional harm to you or your children. If you feel that you have a good reason, check here: ❑ Good Cause

Child's Name (Last, First, Middle)	Absent or Deceased Parent's Name	Absent or Deceased?	Parent's SSN	Last Known Address	Sex (M/F)	Race (Code)	Date of Death

5. **People with health insurance can still receive medical assistance.** Does anyone for whom you want benefits to continue have other health insurance? ❑ YES ❑ NO

If YES, please provide the following information:

Name(s) of Person(s) With Health Insurance	Name of Policyholder	Name and Address of Insurance Company	Group Number	Policy Number

6. Does anyone for whom you want benefits to continue participate in Medicare? ❑ YES ❑ NO
(Medicare issues a white card with red and blue stripes.)

Person(s) Covered	Claim Number	
		❑ Part A ❑ Part B
		❑ Part A ❑ Part B

7. Does anyone for whom you want benefits to continue have a claim(s) pending for personal injury from a car accident or injury on the job? ❑ YES ❑ NO If YES, list names.

Part D:

1. Does anyone for whom you want benefits to continue have cash on hand, checking and savings accounts, stocks and bonds, burial funds, etc.? ❑ YES ❑ NO

Person(s) with Asset	Financial Institution & Address	Account Number	Balance/Market Value

2. Does anyone for whom you want benefits to continue have life insurance? ❑ YES ❑ NO

Person(s) with Life Insurance	Name of Insurance Company	Policy Number	Face Value	Amount paid if you cancel policy	Type (Whole or Term)
			$	$	❑ Whole ❑ Term
			$	$	❑ Whole ❑ Term

Part E:

Notifications:

1. Recertification Processing - You are responsible for submitting all of the documents and providing all of the Information in connection with the recertification of your Medical Assistance. You will receive a notice from us when we receive your completed recertification form, letting you know that we have received it. If you return all of the documents requested before the end of your current Medical Assistance eligibility period, the Department of Human Services MUST either approve or disapprove your request or continue your eligibility until a determination of ineligibility is made and you are given written notice of that decision. If you are determined no longer to be eligible for Medical Assistance, you have a right to a hearing to challenge that determination. If you have not received written notice that your recertification has either been approved or denied by the end of your current eligibility period, and your eligibility has not been continued, you can obtain free legal assistance by calling the firm of Terris, Pravlik & Millian, 1121 12th Street, N.W., Washington, D.C. 20005, (202) 682-0578.

   NOTE: FOSTER PARENT
   THIS FORM MUST BE RETURNED TO YOUR SOCIAL WORKER AT 400 6th STREET, SW, IN ORDER TO CONTNUE ELIGIBILITY. IF YOU HAVE ANY QUESTIONS CALL YOUR FOSTER CARE WORKER ON (202) 727-7107.

   Eligibility Verification System (EVS) - If, during a period when you are eligible for Medical Assistance, the EVS informs you or your provider that you are not eligible for Medical Assistance and you dispute that determination, you may obtain free legal assistance by contacting Terris, Pravlik & Millian, 1121 12th Street, N.W., Washington, D.C. 20005, (202) 682-0578. Your provider has been instructed to call the EVS backup system.

   D.C. Health Check/EPSDT program - The D.C. Health Check/EPSDT Program provides free check-ups and treatment to Medical Assistance eligible children under age 21. This program is very important and can be obtained from any doctor or clinic participating in the Medical Assistance program. The D.C. Healthy Check/EPSDT Program also helps in scheduling appointments and providing transportation to the doctor's office. For help in scheduling appointments and providing transportation, call 1-800-MOM-BABY. For more information about the program, call (202) 442-9110.

2. If you have incurred out-of-pocket expenses for medical services or prescriptions after you applied for Medical Assistance (or the D.C. Health Check/EPSDT program) or in the three months prior to your application, you may be eligible for reimbursement from the District. You must make your claim within six months of when you make the out-of-pocket payment or within six months of when you are notified that you are eligible for Medicaid, whichever is later. You may obtain free legal assistance and help in making a claim from Terris, Pravlik & Millian at (202) 682-0578 or you may call the Recipient Claims Research Team at (202) 698-2000.

3. Anyone who knowingly aids or encourages another person in obtaining or attempting to obtain Medical Assistance by giving false or incomplete information is punishable for fraud. He/she might be fined, imprisoned or both. (D.C. Code, Section 3-218).

4. I declare to the best of my knowledge and belief, that the information on this application for Medical Assistance is true, correct and complete. I understand that receipt of Medical Assistance will be paid for from Federal and District funds, and that any false claims, statements or incomplete information will be prosecuted under applicable Federal or District laws.

_____	_____
Signature of Applicant or "X" Mark	Date
_____	_____
Signature of Spouse or "X" Mark	Date
_____	_____
Signature of Witness or "X" Mark	Date
_____	_____
Signature of Conservator/Representative Payee/ Facility Representative	Date